Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

Meticillin Resistant *Staphylococcus aureus* (MRSA) Prevention and Control Policy

POLICY

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1.0 INTRODUCTION

Modern healthcare has brought unprecedented benefits to generations of patients and their families. Today's healthcare though, brings risks as well as benefits. No risk is more fundamental than the risk of infection.

The Health and Social Care Act 2008 (DH, 2015), states that:

> 'effective prevention and control of healthcare associated infections has to be embedded into everyday practice and applied by everyone. It is particularly important to have a high awareness of the possibility of healthcare associated infections in both patients and healthcare workers'.

The Sherwood Forest Hospital NHS Foundation Trust (Trust) is committed to reducing and managing risk, ensuring effective and safe practice. This policy has been developed to provide a practical document, which reflects current best practices, to equip all healthcare professionals at the Trust with the necessary information on the recognition, management, screening and treatment of Meticillin resistant *staphylococcus aureus* (MRSA) colonisation and/or infection, it describes the accountability framework for implementation of the protocols that are recommended within the Trust for the prevention and control of MRSA, thereby reducing patient morbidity and mortality.

2.0 POLICY STATEMENT

The purpose of this policy is to provide all staff within the Trust with robust information on the management of patients with MRSA whilst an in-patient at our Trust. It includes all clinical and non-clinical staff (including visiting staff to the Trust) and all clinical areas and patient groups. There are no exclusions to this policy.

3.0 DEFINITIONS/ ABBREVIATIONS

Staphylococcus aureus	an organism that colonises the skin, in particular the nose, perineum, armpits, hairline and skin folds
Colonisation	the bacteria are present and may be multiplying on the body but without causing a host response
Infection	if the organism invades the skin or deeper tissues and multiplies to cause a localised or systemic host response. Most infections caused by MRSA are superficial and easily treated
Bacteraemia	blood stream infection, this is a life threatening sepsis that can lead to death if not diagnosed early and treated effectively
MRSA bacteraemia	is a blood stream infection cause by MRSA, this is a life threatening sepsis that can lead to death if not diagnosed early and treated effectively

Decolonisation	treatment for patients who are high risk of acquiring MRSA, to reduce the burden of bacteria colonising the human skin and thereby attempting to minimise the risk of infection
Suppression	treatment used to reduce the colonisation of the skin and nose in patients who are found to be MRSA positive
Outbreak	two or more cases of MRSA identified in the same area within a 28 day period and are the same Spa type
SPA type	to identify if the two/or more samples are the same genetic makeup, therefore related
Trust	Sherwood Forest Hospitals NHS Foundation Trust
Staff	All employers of the Trust including those managed by a third party on behalf of the Trust
UKHSA	United Kingdom Health Security Agency
IPCC	Infection Prevention and Control Committee
IPCT	Infection Prevention and Control Team
HCAI	Healthcare Associated Infection(s)
MRSA	Meticillin resistant *staphylococcus aureus*
MSSA	Meticillin-sensitive *Staphylococcus aureus*
PAS	Medway Patient Administration System
PPE	Personal Protective Equipment
PII	Period of Increased Incidence
RCA	Root Cause Analysis

4.0 ROLES AND RESPONSIBILITIES

Each individual has a clinical and ethical responsibility to carry out effective infection prevention procedures and to act in a way, which minimises the risk to the patient.

4.1 Chief Executive

The Chief Executive is ultimately responsible for ensuring that there are effective arrangements for infection prevention and control.

4.2 Director of Infection Prevention and Control

The Director of Infection Prevention and Control (DIPC) has Trust wide responsibility for the development of strategies and policies for the management of infection prevention and control.

4.3 Infection Prevention and Control Team

The Infection Prevention and Control Team (IPCT) will provide specialist advice regarding Meticillin resistant *staphylococcus aureus (MRSA)*, and ensure this policy is reviewed and amended at the review date, or prior to this following new development in MRSA management research.

4.4 Consultants and Clinical Chairs

Consultants and Clinical Chairs are responsible for ensuring that infection prevention and control policies, procedures and guidance are applied consistently across the clinical team and that they act as a good role model for infection prevention and control. They will actively support all infection prevention and control measures and will have an active role in measuring outcomes and developing action plans for improvement. They will ensure medical teams are allocated appropriately.

4.5 Heads of Nursing/Matrons

Heads of Nursing/Matrons are responsible for ensuring that infection prevention and control policies, procedures and guidance are applied consistently across the clinical team and that they act as a good role model for infection prevention and control. They are also responsible for ensuring that resources are available for all healthcare professionals to undertake effective standard and isolation precautions.

4.6 Sister/Charge Nurse

Sister/Charge Nurses are responsible for ensuring that infection prevention and control policies, procedures and guidance are applied consistently across the clinical team and that they act as a good role model for infection prevention and control. They are also responsible for ensuring that all members of staff under their management control are appropriately trained, have access to appropriate personal protective equipment and adhere to safe practices. To keep clear and contemporaneous records re staff training in relation to MRSA Trust Group Directive suppression treatment of MRSA.

4.7 Clinical Staff

Clinical staff are responsible for complying with the requirements of the Trust Infection Prevention and Control policies, attending appropriate training and using appropriate personal protective equipment. To maintain clear and contemporaneous records regarding patient care in their nursing notes and to maintain records of their own training.

4.8 Non-clinical staff

Non-clinical staff are responsible for complying with the requirements of the Trust Infection Prevention and Control policies, attending appropriate training and using appropriate personal protective equipment.

4.9 Occupational Health

Occupational Health is required to be aware of this policy. Occupational Health is responsible for ensuring that appropriate individual advice is available for staff who are advised they are MRSA positive. Staff need to contact Occupational Health for individual advice if they are advised they are MRSA positive.

4.10 Nominated Infection Prevention and Control Link Representatives and associates

Nominated infection prevention and control link representatives and associates are responsible for disseminating all relevant infection prevention and control information to staff within their own work environment, conducting monthly audits, and supporting the IPCT within their own ward/ department.

5.0 APPROVAL

Following appropriate consultation, this revised policy (v8.1) has been approved by the Trust's Infection Prevention and Control Committee.

6.0 DOCUMENT REQUIREMENTS (POLICY NARRATIVE)

Staphylococcus aureus is a gram positive bacterium and is often referred to as Meticillin-sensitive *Staphylococcus aureus* (MSSA). It is very common and usually lives harmlessly on the skin and in the lining of an individual's nose. *Staphylococcus aureus* is loosely attached to the skin, making it easy to remove by conventional means such as hand washing, skin disinfection prior to invasive procedures. In addition, those that remain on the skin can easily be redistributed to other sites either on the individual affected or others. Also we shed skin scales in vast numbers at all times, these contribute to the development of dust on surfaces and equipment, and can be spread via the airborne route to settle on these surfaces as well as on the floor, hence the importance of environmental and equipment cleaning as a key intervention in the control of *staphylococcus aureus.* **Expert opinion is that direct skin to skin transfer, either from sites on the patient's own body or from healthcare workers hands is much more common than acquisition from the environment**.

Some strains of *staphylococcus aureus* have developed resistance to some of the antibiotics commonly used to treat these types of infection. These strains are known as MRSA, having acquired the mecA gene which confers resistance to a range of antibiotics including all beta-lactams and cephalosporin's. MRSA behaves in the same way as MSSA, there is no evidence that MRSA causes more severe infections than MSSA but treatment is often more difficult and expensive. MRSA is not a significant risk to healthy individuals, including healthcare workers and visitors, but as a complication for vulnerable patients it can be a serious infection with significant impact for example leading to removal of prosthetic implants and potentially death.

6.1 Confidentiality

MRSA is part of the patient's diagnosis. Staff who do not have access to the patients' medical and/or nursing health records **must not** be told the nature of the illness but be given specific infection prevention and control guidance. Divulging a diagnosis inappropriately is a breach of confidentiality.

6.2 Definition for colonisation and infection

The effect of MRSA on individual patients is variable. It is important that staff and patients are aware of the difference between colonisation and infection in relation to MRSA. An individual patient assessment must be undertaken to determine if the patient is colonised or infected and if a suppression therapy needs to be initiated or continued.

Colonisation: isolation of MRSA on one or more occasions from any site in the absence of clinical disease (infection) attributable to MRSA. When a patient is routinely screened for MRSA prior to or on admission, the sites screened are those sites that the bacterium is known to colonise, in other words the microorganism is present on these skin sites but they are not causing the individual any adverse effects. The patient is said to be colonised.

Infection: clinical signs and/or symptoms of infection, such as redness, swelling, discharge, which is confirmed by culture to be MRSA from the site of infection. The term infection is generally used to mean the deposition and multiplication of microorganisms in tissue or on the surface of the body, which are damaged or on mucous membranes, where they can cause adverse effects often resulting in disease (infection). It is impossible to determine from clinical specimens whether an individual has an infection or is merely colonised. In these circumstances the clinical condition of the patient must determine whether they have an infection or not.

Comparing the signs and symptoms of infection and colonisation

Sign and symptom	Colonisation	Infection
Erythema (redness)	**No**	**Yes**
Pyrexia (raised temperature)	**No**	**Yes**
Cellulitis (inflammation of tissue around the wound)	**No**	**Yes**
Odour	**Yes**	**Yes**
Positive swab result	**Yes**	**Yes**
Purulent discharge (pus)	**No**	**Yes**
Excess exudate (fluid)	**Yes**	**Yes**
Local pain	**No**	**Yes**
Local oedema	**No**	**Yes**

6.3 Definition for acquisition

- **Trust acquired:** MRSA isolated for the first time (new isolate) more than 48 hours after admission

- **Non-Trust acquired:** MRSA isolated for the first time (new isolate) within 48 hours of admission.

6.4 Transmission

Although MRSA can be spread by airborne route (following bed making for a positive case) or on equipment, the most common route is by direct contact between individuals, which underlies the importance of good hand hygiene before and after direct patient contact or contact with the patients immediate surroundings i.e. bed curtains, bed table/locker etc.

The problem is due to the ability of MRSA to spread via hands and equipment to patients who are at risk. Those at greatest risk include patients with:

- Indwelling medical devices such as urinary catheters, intravenous catheters
- Skin lesions and wounds
- Chronic skin conditions
- Surgical intervention

6.5 Screening

While screening is not a control measure in itself, it allows focusing of effective infection prevention and control resources on positive patients. From December 2010 all emergency admissions must be screened (DH 2010). Also since April 2009 (DH 2008) all elective admission have been required to be screened for MRSA colonisation in addition to certain categories i.e. chemotherapy patient to be screened at the start of their treatment and then at regular intervals or if clinically indicated as highlighted in ICP 24a MRSA screening policy.

6.6 High risk categories

It is also important that the Trust continues to assess all patients' admission groups for screening according to risk at a local level (DH 2008). Some patients are known to be at higher risk of subsequently developing infection with MRSA as a result of their health care. These patients carry a higher risk of adverse outcomes as a result of MRSA infections and these are more difficult to treat due to antibiotic resistance and this may increase both morbidity and mortality. Patients who are deemed to be a higher risk of adverse outcomes are those requiring complex care including management in high dependency units, intensive care units as well as the following:

- Patients who are social or healthcare staff (due to their exposure to MRSA positive patients)
- Other health related staff may also warrant assessment for screening for example veterinary personnel, who have been found to have a relatively high (18%) carriage rate (Loeffler et al 2005)
- Patients with a previous history of MRSA
- Transfers from hospitals outside the Trust including diagnostic procedures and abroad
- Previous hospital stay (longer than 48 hours) within previous 12 months (UK or abroad)
- Patients admitted from Nursing or Residential Homes
- Patients admitted to the Intensive Critical Care Unit
- Babies admitted to the Neonatal Intensive Care Unit
- All haematology patients
- Patients undergoing an orthopaedic procedure
- Patients having vascular surgery
- Patients with central lines (note: 3M Tegaderm CHG dressing to be used)
- Patients with chest drains
- Chronic wounds including all diabetic foot ulcers
- Patients with indwelling devices e.g. Urinary/suprapubic catheters and nephrostomy/urostomy site etc (this list is not exhaustive)

6.7 Admission

All patients for elective surgery should be assessed prior to surgery, and their MRSA status should be known at the time of admission, and high risk patients should have commenced a course of decolonisation therapy prior to admission. Patients who have not been assessed pre-admission pose a risk not only to themselves but also to others if admitted and subsequently found to be colonised with MRSA.

6.8 Treatment of MRSA colonisation

Complete eradication of MRSA is not always possible, but a decrease of carriage can reduce the risk of transmission, as well as reduce the risk of inoculation to the patient's own surgical wound during surgery. The efficacy of any suppression regime will depend on the presence of wounds, skin lesions and foreign bodies such as urinary catheters. The suppression therapy is reserved for the treatment of patients who are confirmed MRSA positive. The MRSA suppression therapy should be carried out under the advice of the IPCT.

- **Decolonisation therapy:** The use of an antibacterial hair and body wash and nasal ointment, for patients who are in the high risk categories, to reduce the burden of bacteria colonising the human skin and thereby attempting to minimise the risk of infection in high risk patients. The treatment is prescribed and administered for 5 days and this includes hair washing on 2 days (Treatment given in line with clinical area where patient is).

  Antibacterial washes must be used un-diluted and in the same way as a liquid soap. Following the completion of treatment it must be discarded.

- **Suppression therapy:** The use of antibacterial hair and body washes, antibacterial nasal ointment or cream to reduce the colonisation of the skin and nose in patients **who are found to be MRSA positive**. The treatment is prescribed and administered for 5 days and this includes hair washing on 2 days.

  - Nasal Octenisan for 15 doses over 5 days (3 times a day
  - Octenisan hair and body wash
    - Hair wash twice during the 5 day body wash cycle
    - Body wash daily for 5 days

  Following the completion of treatment the Nasal Octenisan and Octenisan must be discarded, if a second course of suppression therapy is required use a new supply of nasal Octenisan and Octenisan hair and body wash.

- **Neonates:** For any Neonates who have a positive MRSA result the suppression treatment that should be used is:
  - Nasal Octenisan for 15 doses over 5 days (3 times a day
  - Octenisan antibacterial hair and body wash
    - Hair wash twice during the 5 day body wash cycle
    - Body wash daily for 5 days

If the result is not from a screen, for instance the result was obtained from a wound swab, blood culture, urine sample then a MRSA screen from the nose and perineum, skin breaks etc in accordance with the MRSA screening policy must be obtained, prior to commencing the MRSA suppression therapy (this must be commenced prior to these screen results being known).

6.9 Prescribing

The suppression therapy should be prescribed by a Clinician. Mupirocin and Naseptin are **prescription only** medications hence require prescribing on the patient's medication chart. Octenisan body wash and nasal ointment is a cosmetic product and therefore does not require a prescription, but **its administration must be documented daily** on Nervecentre EPMA to ensure that it is acknowledged as being given throughout the course of the treatment. Any patient being given Octenisan must be given the patient information leaflet as well as being instructed in the correct use of this product (see Appendix A).

6.10 Restarting decolonisation after a period of ward leave

Any patient going on weekend/ward leave who falls in the high risk category for MRSA must be treated with decolonisation treatemtn for five days on their return.

6.11 Patient identified as MRSA positive on screening following admission

When a patient is shown to be colonised with MRSA after screening, the decolonisation treatment must be changed to suppression therapy for 5 days.

6.12 MRSA clearance

The first post MRSA treatment screen must be taken >48 hours after stopping suppression treatment.

Re-screening result (positive): a positive results indicates that colonisation is on-going and the suppression therapy should be repeated for in-patients. If colonisation is still on-going after 2 cycles of the suppression therapy or recurs at a later date the IPCT must be consulted before any further suppression therapy is administered.

Re-screening result (negative): a negative result indicates that colonisation is not on-going and suppression therapy will not need to be repeated although contact infection prevention and control measures must continue until 3 consecutive negative screens 7 days apart have been received.

6.13 Alerting mechanisms

Patients found to be MRSA positive must be clearly identified, so that carriers may be immediately recognised on subsequent admissions to the Trust. For all patients with a previous history of MRSA and newly diagnosed MRSA, they will be alerted in the following manner:

- **"MRSA Positive"** using printed "alert" labels will be placed in the medical notes
  - 'stop alert look inside' label will be placed on the outside of the medical notes
  - 'Alert' label will be placed on the red alert notification sheet which is located inside the medical notes
- These alerts **must not** be removed (if medical notes do not have an alert label displayed please contact the IPCT)
- Careflow Patient Administration System alert will be instigated by the IPCT

6.14 Management of MRSA positive patient and histories of MRSA

Patient care **must not** be compromised by the control measures implemented.

- **Communication**: it is the responsibility of the medical staff to inform the patient and relatives of the MRSA status. Written information is available via the intranet (patient

information leaflet), which provides information for patients and their relatives/carers. Information must be provided by the nursing staff following the patient being informed by the medical staff. The discussion held must be recorded in the patient medical notes.

- **Contact isolation precautions:** single/isolation with en-suite facilities, with doors kept shut to minimise the spread to adjacent areas. If this is likely to compromise patient care a risk assessment must be made (see Appendix B), and documented by the nursing staff as to whether the door may be kept open. However, doors **must** be closed for procedures or whenever staff and visitors are present. Contact isolation precautions are required for all known or suspected patients with MRSA. An appropriate sign stating which precautions are required must be displayed on the door of the room or above the bed space if patient has to be nursed in a bay.

  If a patient is being nursed in a Bay, and then identified to be MRSA positive they should be moved to a single room and contact isolation precautions commenced. The bed space **must** be cleaned with a Amber clean and the curtains changed. If the patient has been in the bay for more than 24 hours, the other patients in this bay need to be screened for MRSA (potential contacts).

- **Other microorganisms, such as *Clostridium difficile,* may take precedence over MRSA colonisation for isolation.** Any exception **must** be discussed and agreed with the Sister/Charge Nurse or Matron for the area and the IPCT

- **Personal protective equipment (PPE):** yellow disposable plastic apron and gloves must be worn by **all** staff in contact with the patient, contact with secretions, blood and/or body fluids, the patient's immediate environment, linen, waste and equipment. These are **single use items,** and are disposed of as Orange AT waste. Face and eye protection is not normally required unless specifically advised by the IPCT

- **Hand hygiene:** good hand decontamination procedures with soap and water, followed by the use of alcohol based hand rub prior to and after all patient contact, contact with the patients environment and removal of PPE. Hand washing is the single most important means of controlling the transmission of MRSA, as well as other microorganisms and remains the cornerstone of good infection prevention and control practices

- **Waste disposal:** all waste generated form the patient must be processed as orange AT waste (orange bags) and disposed of accordingly to Trust policy (Refer to Trust Waste Management Policy)

- **Equipment:** ideally all equipment should be dedicated to the use of the patient in contact isolation and kept in their room until discharge or discontinuation of isolation precautions. Equipment shared between patients such as stethoscope must be thoroughly cleaned using a universal sanitising wipe before being used on another patient. All MRSA positive patient should have a single patient use blood pressure

cuff for their isolation period. All equipment must be decontaminated prior to removal from the patient's room. Any equipment on loan, such as special mattresses, should be returned after they have been decontaminated and a 'decontamination certificate' form completed.

- **Laundry:** used linen must be treated as infected and placed in a water-soluble (alginate) red bag then placed inside a white plastic bag prior to being removed from the side room and placed immediately into the disposal hold. Any soiled patient clothing must be placed in a water-soluble bag and then into a patient property bag for relatives to take home. Relatives must be informed that the soiled clothing is there and instructed in the use of the red water soluble bag.

- **Environment:** the bed space remains the responsibility of the domestic staff and must be cleaned at least daily in accordance with Trust policy and as per cleaning schedules. Following discharge of the patient or discontinuation of standard isolation precautions, an Amber clean of the patient's room is required.

- **Patient immediate surrounding equipment:** any equipment not for dedicated use must be removed from the room, any monitoring equipment must be cleaned between patients. Single patient use disposable blood pressure cuffs and tourniquets must be considered (purchased at ward level). If the patient is moved to a different bed, the integrity of the mattress cover and pillows must be ensured, the mattress and pillows must be checked for contamination by ward staff. If the integrity is breached:

    - Mattress: decontaminate the external aspects of the mattress, complete the 'decontamination certificate', and log call via the Helpdesk (extension 3005). The portering team will collect the mattress and dispose of it in accordance to Trust policy (Refer to the Trust waste policy)
    - Pillows: decontaminate the external aspects of the pillows and place them into an orange waste bag and return to laundry, where a replacement pillow will be issued.

- **Visitors:** are not required to wear PPE unless they are providing and/or assisting with direct patient care, however, they should be asked to wash their hands on entering and leaving the room

- **Patient activity:** all known or suspected MRSA positive patients nursed in a side room are able to mobilise outside their room unless they have a productive cough, exudating wounds, or an exfoliating skin condition when advice should be sought from the IPCT. Patients should be discouraged from entering other patients bay areas, day rooms or ward kitchens, but they can go off the ward, but should not visit other inpatients. Patients should wash their hands or use the alcohol based hand rub prior to leaving their room

6.15 Treatment and clinical advice for MRSA infection

Patients suspected of having a MRSA infection, the patient's medical team **must** discuss treatment options with the Consultant Microbiologist and refer to the Antimicrobial policy and guidelines.

6.16 Prevention through appropriate antibiotic prescription

Antibiotics should be prescribed only when there is clinical evidence of bacterial infection. The indications for starting antibiotics **and** a stop/review date for the antibiotic must be clearly documented in the patient's medical records. The Trust antibiotic guidelines for adult patients are available on the Antibiotic intranet website

All antibiotics should be reviewed with results of microbiological testing. Polypharmacy with regards to antibiotics must be minimised. Antibiotics started inappropriately or without sufficient evidence must be stopped after medical review. Antibiotics must be stopped where microbiology results do not support a diagnosis of bacterial infection or an alternative diagnosis of non-infectious aetiology has been made. Consultants must review antibiotic prescribing on all their ward rounds, stopping unnecessary prescriptions and changing those that do not comply with guidelines, as should junior medical staff on their own ward rounds.

6.17 Operating theatre management/Endoscopy/Radiology

Where possible, all known MRSA positive patients and those admitted for surgery without pre-admission screening should be placed last on the list, or 15 minutes be allowed between cases for comprehensive environmental cleaning and air change to take place. Standard precautions require a robust adherence to optimum peri-operative clinical practices and should preclude any additional precautions being required. Therefore, prior to any planned surgery, efforts should be made to minimise the risk of infection through topical and systemic decolonisation, and prophylactic antimicrobial chemotherapy where appropriate.
Preparing the patient for theatre:

- Medical and nursing staff must inform the theatre co-ordinator that the patient has MRSA colonisation/infection. The patient's confidentiality must be maintained
- Medical staff should consult the Consultant Microbiologist to discuss chemoprophylaxis and inform the theatres of the known/suspected case

If MRSA positive patients are anaesthetised in the anaesthetic room it is imperative measures are taken to reduce potential contamination of equipment in the room prior to being used by another patient:

- Powder-free, disposable non-sterile gloves and disposable plastic apron must be worn by all staff for contact with the patient, and their environment and equipment
- Clean all patient contact areas with a universal sanitising wipe
- Clean and disinfect/sterilise all re-usable equipment

MRSA positive patients who are last on the list should be recovered within the operating theatre where appropriate; however, they can be recovered in the main recovery area with the following precautions:

- Recover as far as possible from other patients, leaving a minimum of one bed space between
- Remove all unwanted equipment and unnecessary disposables from the bed space area
- Standard isolation precautions to be followed at all times

- Conduct hand hygiene prior to and after contact with the patient, their immediate surrounding and equipment
- Clean the bed space after the patient has been transferred with Nadcc 1,000 ppm/peracetic acid solution. If patient stay exceeds 8 hours, all surfaces within the patient area must be wiped by ward staff using Nadcc 1,000 ppm solution/peracetic acid. This must be followed by a thorough domestic clean including a curtain change. On transfer of the patient to the ward, request an isolation clean through the helpdesk on extension 3005
- Linen to be treated as infected linen (refer to section 5.14)

6.18 Low risk areas

This includes areas such as outpatients, diagnostic imaging, etc where the risk of acquisition and spread are deemed to be minimal as long as standard precautions are followed at all times, paying particular attention to hand washing and the use of PPE for clinical procedures. Examination/procedure couches must be cleaned between each patient and clean paper roll applied. All equipment which has had direct contact with the patient must be cleaned prior to use for another patient, using green Clinell wipes.

6.19 Transfer of the patient

Transfer to other hospital, between wards and within wards and departments must be kept to a minimum, but when necessary, the actions detailed below must be adhered to:

- On transfer of a patient to another ward or Trust the ward staff must inform a member of the IPCT, during the next office hours on extension 3525 or leave a message on the answer phone, or contact the IPCT via Vocera

- All internal transfers, information about the patient's infectious status must be provided both verbally and written to the receiving ward. Patients who are MRSA colonised can visit other hospital department for treatment, investigations following consultation with the Sister/Charge Nurse. Procedures should ideally be booked at the end of the session to allow time for cleaning and disinfection of staff and patient contact areas.

- Portering staff must wear disposable gloves and aprons **only** when required to have direct contact with the patient for instance helping with moving and handling. PPE must be disposed of as clinical waste, and hands must be decontaminated. Hands must also be decontaminated prior to moving the patient through the hospital. The trolley/wheelchair must be decontaminated with the universal sanitising wipes after use and prior to use for another patient
- Transfer to other hospitals: the transferring ward is responsible for informing the receiving hospital if the patient is colonised/infected with MRSA. Before transfer, the clinician responsible for the patient care should inform the receiving ward and the Infection Prevention and Control Team of the receiving hospital. A transfer form must be completed for all patients giving full details of the MRSA status and MRSA treatments.

- Patients with MRSA should be discharged promptly, when their clinical condition allows to either their own home or social care i.e. care home. No special precautions are required. The care home must be informed of any specific requirements prior to being transferred. Patients GP/District Nurses must be informed of the patient's MRSA status on the discharge letter and any on-going treatment by the discharging medical team. Once discharged, continuation of care concerning the patients MRSA status is the responsibility of the GP and its their responsibility to inform the Community IPCT

- Transport and the use of ambulances: there is no evidence that ambulance staff/hospital drivers or their families are put at risk by transporting patients with MRSA. Ambulance liaison must be made aware of the MRSA status of the patient by the ward or department staff, the ambulance must be cleaned and decontaminated in accordance with their policies

- Liaison with outside agencies: if input from outside agencies is required, the ward as normal must arrange this. A member of the trust IPCT will give advice if required. Once the patient has been discharged, further advice can be obtained from the Community IPCT

- Patients should be advised that if they are re-admitted to hospital at any time, they should advise the admitting staff that they have previously been identified as colonised/infected with MRSA, in order to ensure that they are appropriately managed.

It is crucial that the patient, their relatives and/or carers must be fully briefed on MRSA and informed that there is no risk of infection to healthy relatives and contacts outside the hospital, and that normal social interactions should not be compromised. Where contact is with relatives or friends who may be hospital workers with patient contact or with individuals who may be receiving hospital treatment, the individual case should be reviewed by a member of the IPCT and Occupational Health (OH).

6.20 Deceased patients

There is no specific risk from the body to relatives, nursing staff or undertakers. The precautions taken in laying out the deceased patient must be the same as those observed during life. The patient should **only** be placed in a cadaver bag before being transferred to the mortuary if there is the potential for body fluids to leak from the deceased during transportation. Any lesions that leak should be covered with an impermeable dressing. There are no requirements to use a cadaver bag because the deceased was MRSA positive.

6.21 Management of MRSA outbreak

If there is deemed to be an increased amount of MRSA in a ward the IPCT will convene an Period of Increased Incidence (PII) or an outbreak meeting. It is deemed as an outbreak if there are two or more positive cases on the same area within a 28 day period and the samples are the same SPA type. The Sister/Charge Nurse will be informed of the incident through the datix system.

6.22 Post Infection Review

All MRSA bacteraemia must undergo a Post Infection Review (PIR). This process will be led by the Consultant in charge of the patient's care. This process requires a time line to be completed from the patient's admission to time of the blood culture being taken.
Also a post infection review will be requested if MRSA is listed as a patient's cause of death.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
New MRSA positive results	IPCT	Audit	Monthly	IPCC
Treatment Compliance	IPCT	Audits	Monthly	IPCC
Outbreak Investigations	IPCT	Audits/Meetings	As occurs	IPCC

8.0 TRAINING AND IMPLEMENTATION

All healthcare workers will be aware of the Infection Prevention and Control Policies for the Trust by attending the mandatory, induction day, annual clinical update programmes, and formal infection prevention and control sessions and by their Sister/Charge Nurse of clinical and non-clinical areas. All training sessions are outlined in the Trusts Training, Education and Development Opportunities Resource File. Infection prevention and control training on the basic principles is part of the Trust wide mandatory training for all staff and is monitored via attendance records.

All clinical staff are to be aware of and have read this policy. Information about any updates will be communicated via the Divisional Management Team/weekly bulletins.

9.0 IMPACT ASSESSMENTS

Delete/ amend as applicable:

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix C
- This document is not subject to an Environmental Impact Assessment

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- Department of Health. 2014. Implementation of Modified Admission MRSA Screening Guidance for NHS (2014). London
- Coia et al. 2022 *Joint Healthcare Infection Society (HIS) and Infection Prevention Society (IPS) guidelines for the prevention and control of meticillin-resistant Staphylococcus aureus (MRSA) in healthcare facilities.* Journal of Hospital Infection
- Department of Health (DH). 2007. *Saving Lives: reducing infection delivering clean safe care*
- DH. 2015. *The Health & Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance*
- DH. 2014. Epic 3 guidelines
- Loeffler et al. 2005. Prevalence of methicillin-resistant *staphylococcus aureus* among staff and pets in a small animal referral hospital in the UK. Journal of Antimicrobial Chemotherapy. 56 p692-697

Related SFHFT Documents:

- MRSA Screening Policy (ICP24a)

11.0 KEYWORDS

Infection, Colonisation, Suppression, Decolonisation

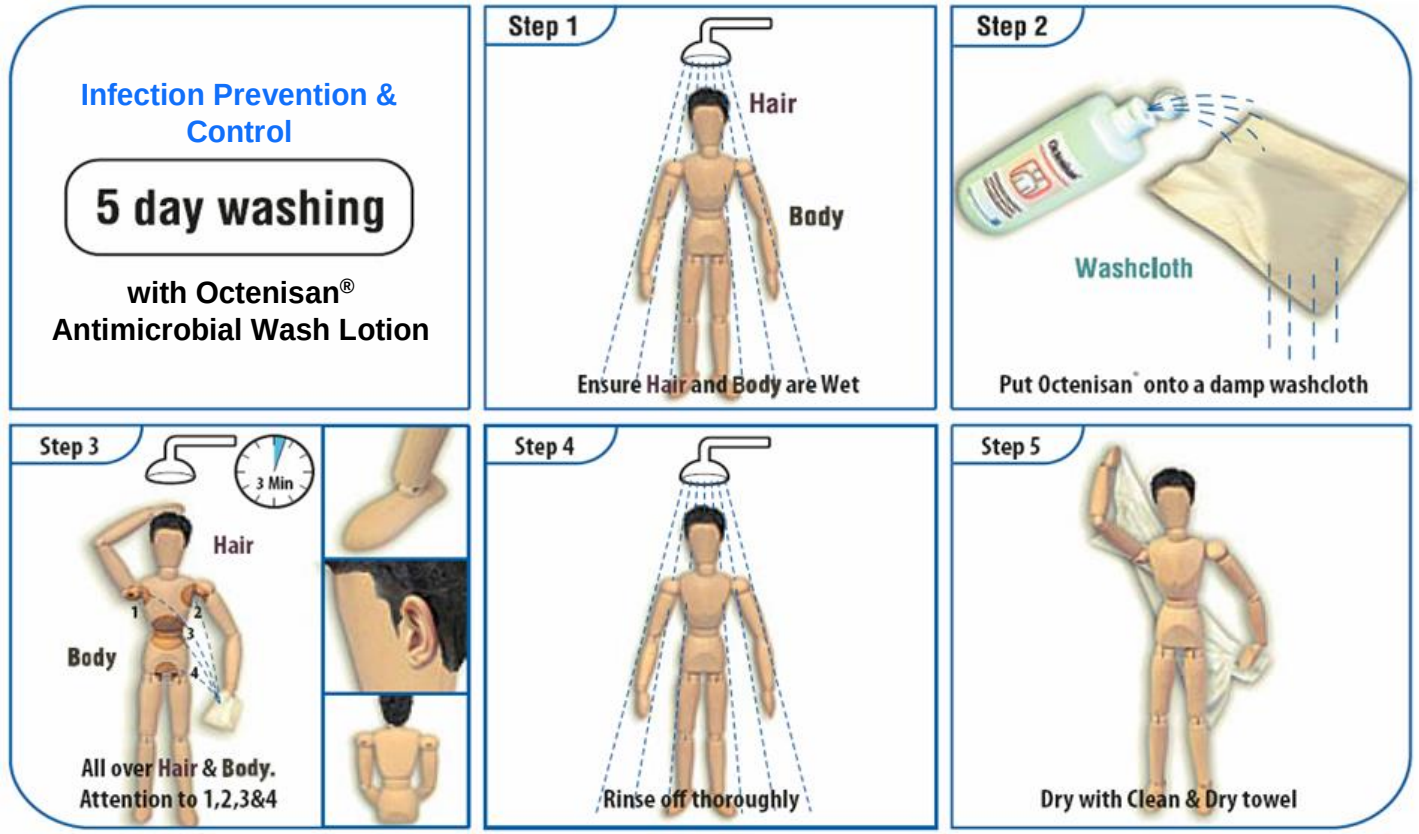
12.0 APPENDICES

Appendix A – Octenisan Information Leaflet
Appendix B – MRSA tool for placement of patients within the bays
Appendix C – Equality Impact Assessment

Appendix A

OCTENISAN INFORMATION LEAFLET

Sherwood Forest Hospitals NHS
NHS Foundation Trust



Day 1	Day 2	Day 3	Day 4	Day 5
Body	Body & Hair	Body	Body & Hair	Body

For more information, please ask a member of staff

Sept 08 BB1

Appendix B

MRSA risk assessment tool for placement of patients within the Bays.

All patients identified as being colonised or infected with MRSA must be nursed in a single room, however in the event of unavailability of a single room accommodation please asses using the following guidance:

High risk:

- MRSA identified at the following sites:
  a) Deep leaking wounds
  b) Gentamicin/Mupiricin resistant MRSA
  c) Multiple wounds/pressure ulcers
  d) Dermatitis or other skin conditions
  e) Expectorating sputum
  f) Multiple body sites on screening
  g) Urine and urinary catheter in situ
- Patients meeting any of the above criteria **must** be nursed in a side room with skin/wound precautions
- Ensure the electronic symbol for infection risk has been activated on the electronic white board

Moderate risk:

- MRSA identified at the following sites:
  a) Nasal only
  b) One or two superficial wounds, healing and covered with a dressing
  c) One or two body sites i.e. nasal and groin
  d) One full set of negative screens
  e) Patient confined to bed area
- Nurse in a side room with skin/wound precautions
- In the absence of a side room, patients meeting any of the above criteria can be nursed in a bay area next to a hand wash sink, with skin/wound precautions. Avoid placing patient next to other patients with wounds, IV lines, urinary catheters
- Ensure the electronic symbol for infection risk has been activated on the electronic white board
- As soon as a side room becomes available the patient should be transferred from the bay to the side room

Low risk:

- Awaiting MRSA results, patient not identified as high risk (see table below)
- Nurse in a side room with skin/wound precautions
- In the absence of patients meeting any of the above criteria can be nursed in a bay area next to a hand wash sink, contact precautions

High risk patients:

This list is not exhaustive

Patients who are social or healthcare staff
Other health related staff for example veterinary personnel
Previous history MRSA
Previous hospital stay (longer than 48 hours) within previous 12 months (UK or abroad)
Chronic wounds including diabetic food ulcer
All orthopaedic patients
All vascular surgical patients
All haematology patients
Transfers from hospitals outside of Trust including diagnostic procedures and abroad
Patients admitted for Care Home (Nursing/Residential)
Patients admitted to Intensive Critical Care Unit
Babies admitted to the Neonatal Intensive Care Unit
Patients with central venous catheters (CVC)
Patients with chest drains
Patients with indwelling devices i.e. urinary catheter, nephrostomies
Patients with urostomies

APPENDIX C – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Meticillin Resistant *Staphylococcus aureus* (MRSA) Policy			
New or existing service/policy/procedure: Existing policy			
Date of Assessment: 12/12/2022			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	None	None	None
Gender	None	None	None
Age	None	None	None
Religion	None	None	None
Disability	None	None	None
Sexuality	None	None	None
Pregnancy and Maternity	None	None	None
Gender Reassignment	None	None	None
Marriage and Civil Partnership	None	None	None
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	None	None	None

What consultation with protected characteristic groups including patient groups have you carried out? • Sent to all members of IPCC
What data or information did you use in support of this EqIA? • National guidance
As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? • No
Level of impact From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact: **Low Level of Impact** *(Delete as appropriate)* For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.
Name of Responsible Person undertaking this assessment: Sally Palmer
Signature: **S Palmer**
Date: 12/12/2022